

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04523

4524

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Caroline</u> ✓ | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) <u>5½ years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greensboro</u> | | 05X-2 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>None</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>John Wesley Baynard</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 13 1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>12/5/1883</u> | 9. AGE last birthday <u>72</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Greensboro, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James M. Baynard</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Eveland</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Hospital Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 1 IMMEDIATE CAUSE (A) <u>Uremia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> | |
| 2 ANTECEDENT CAUSE(S) DUE TO (B) <u>Pyelonephritis</u> | | | | | | <u>2 months</u> | |
| 3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congenital Athetosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>10/17</u> , 19 <u>50</u> , to <u>4/13/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr. 13</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>L.V. Maldve, M.D.</u> ADDRESS (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Md.</u> DATE SIGNED <u>4/13/56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/16/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Greensboro</u> | | LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>4-16-56</u> | | REGISTRAR'S SIGNATURE <u>May W. Hollaway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaix, Greensboro, Md.</u> | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1951

FILE NO.

1. Name of deceased (Print or type)

2. Sex (Male or Female)

3. Date of birth

4. Place of birth

5. Date of death

6. Time of death

7. Cause of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Signature of informant

12. Signature of funeral director

13. Signature of coroner

14. Signature of health officer

15. Signature of registrar

16. Signature of informant

17. Signature of funeral director

18. Signature of coroner

19. Signature of health officer

20. Signature of registrar

21. Signature of informant

22. Signature of funeral director

BUREAU V. S.

APR 15 1956

RECEIVED

4525

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg 05x.2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 Deer's Head State Hospital | | d. STREET ADDRESS 321 S. Main Street | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle C. Last Bennett | | 4. DATE OF DEATH Month April Day 5 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/2/1877 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Felton, Delaware | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George N. Carson | | 14. MOTHER'S MAIDEN NAME Ella Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Hospital Records | | Address | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs 10 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old CVA | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | |
|---|---|--|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - | 20f. (City or town) (County) (State) - |
| 21. I certify that I attended the deceased from Sept. 27 , 19 54 , to April 5 , 19 56 , that I last saw the deceased alive on April 4 , 19 56 , and that death occurred at 2 A. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. V. Maldve, M. D. | | ADDRESS (Street, city or town, state) Deer's Head State Hospital, Salisbury, Maryland | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | DATE SIGNED 4/5/56 | |

| | | | |
|---|------------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/7/56 | 22c. NAME OF CEMETERY OR CREMATORY Barratt's Chapel Cem. | 22d. LOCATION (City, town, or county) (State) Frederica, Delaware (Kent Co.) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Stanley Williams | | ADDRESS Federalsburg, Md. | 24a. REC'D BY REGISTRAR DATE 4-6-56 |
| | | 24b. REGISTRAR'S SIGNATURE Mary W. Holloman | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1956

RECEIVED

4526

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12 Salisbury</i> | | | | c. LENGTH OF STAY IN 1b <i>1 day</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>82 Peninsula General Hospital</i> | | | | d. STREET ADDRESS <i>Near Allen's Corner</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Clarence</i> Middle <i>E.</i> Last <i>Bowdle</i> | | | | 4. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1956</i> | | | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>March 17, 1894</i> | |
| 9. AGE (In years last birthday) <i>62</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Owner</i> | | 11. BIRTHPLACE (State or foreign country) <i>Caroline Co., Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | |
| 13. FATHER'S NAME <i>Daniel Bowdle</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Addie Henry</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>214-36-5873</i> | | 17. INFORMANT Address <i>Mrs. Clarence E. Bowdle, Federalburg, Md. RFD</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x Cerebral Thrombosis</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <i>4-23, 1956</i> to <i>4-24, 1956</i> , that I last saw the deceased alive on <i>4-24, 1956</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>W. S. Colles, Jr.</i> | | | | ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>4-24-56</i> | | | |
| PHYSICIAN'S NAME (Type) _____ | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>April 28, 1956</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Federalburg, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton and Son</i> | | | | ADDRESS <i>Federalburg, Md.</i> | | | |
| 24a. REC'D BY REGISTRAR <i>MAY 1 1956</i> | | | | 24b. REGISTRAR'S SIGNATURE <i>Mary K. Holloway</i> | | | |

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04526

4527 CERTIFICATE OF DEATH

Reg. Dist. No. 331

| | | | | | | | |
|--|------------------------------------|---|-----------------------------------|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mardela</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | | | STREET ADDRESS <u>R. F. D. #1</u> | | (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>CARRIE</u> (First) <u>BROWN</u> (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL</u> <u>16</u> 19 <u>56</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>8/2/13</u> | 9. AGE last birthday <u>42</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Levin Roberts</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hattie Gaines</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Otho Roberts Delaware Del</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 624X IMMEDIATE CAUSE (A) <u>Generalized peritonitis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Salpingo-oophoritis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 3-29, 1956, to 4-16, 1956, that I last saw the deceased alive on 4-15, 1956, and that death occurred at 1:00 P.M. from the causes and on the date stated above. SIGNATURE <u>Stedman W. Smith</u> M.D. <u>706 Camden Ave Salisbury</u> DATE SIGNED <u>4-16-56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/19/56</u> | | NAME OF CEMETERY OR CREMATORY <u>MT Zion Cem.</u> | | LOCATION (City, town, or county) (State) <u>Shoptown, Md</u> | |
| 24. REC'D BY REGISTRAR <u>APR 20 1956</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES B. DODD</u> | | ADDRESS <u>Easton, Md</u> | |

RECEIVED
APR 30 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4528 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04527

Reg. Dist. No. 332

| | | | | | | | |
|---|------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u> | | c. LENGTH OF STAY IN 1b <u>life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, 12</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>South of College Ave. on R. R. tracks</u> | | | | d. STREET ADDRESS <u>Elberta Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Linwood</u> Middle <u>Lawrence</u> Last <u>Bundle</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>19 56</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) <u>55</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Elbert Bundle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Alexandria Cartwright</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Mid State Police Dept</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost, (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walked on the tracks and turned his back to the train.</u> | | | | | |
| 20c. TIME OF INJURY Hour <u>3:55</u> a.m. <u>4-28-56</u> 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R. R. tracks</u> | | 20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>5-1-56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u> | | 22b. DATE THEREOF <u>5-4-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Norfolk Co</u> <u>va</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Garland Orelton</u> | | | | ADDRESS <u>va</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-2-56</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, showing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF ATTENDING PHYSICIAN | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF WITNESSES | | 17. SIGNATURE OF FUNERAL HOME | | 18. SIGNATURE OF BURIAL PLACE | |
| 19. SIGNATURE OF CEMETERY | | 20. SIGNATURE OF INTERVIEWER | | 21. SIGNATURE OF REPORTER | |
| 22. SIGNATURE OF CLERK | | 23. SIGNATURE OF RECEPTIONIST | | 24. SIGNATURE OF TELEPHONE OPERATOR | |
| 25. SIGNATURE OF MAIL ROOM | | 26. SIGNATURE OF RECORDS SECTION | | 27. SIGNATURE OF IDENTIFICATION SECTION | |
| 28. SIGNATURE OF LABORATORY | | 29. SIGNATURE OF RADIOLOGY | | 30. SIGNATURE OF PATHOLOGY | |
| 31. SIGNATURE OF ANATOMY | | 32. SIGNATURE OF PHYSIOLOGY | | 33. SIGNATURE OF PHARMACOLOGY | |
| 34. SIGNATURE OF TOXICOLOGY | | 35. SIGNATURE OF MICROBIOLOGY | | 36. SIGNATURE OF IMMUNOLOGY | |
| 37. SIGNATURE OF EPIDEMIOLOGY | | 38. SIGNATURE OF PUBLIC HEALTH | | 39. SIGNATURE OF COMMUNITY HEALTH | |
| 40. SIGNATURE OF ENVIRONMENTAL HEALTH | | 41. SIGNATURE OF OCCUPATIONAL HEALTH | | 42. SIGNATURE OF SCHOOL HEALTH | |
| 43. SIGNATURE OF MENTAL HEALTH | | 44. SIGNATURE OF SUBSTANCE ABUSE | | 45. SIGNATURE OF ADDICTION | |
| 46. SIGNATURE OF TUBERCULOSIS | | 47. SIGNATURE OF HIV/AIDS | | 48. SIGNATURE OF CANCER | |
| 49. SIGNATURE OF HEART DISEASE | | 50. SIGNATURE OF LUNG DISEASE | | 51. SIGNATURE OF KIDNEY DISEASE | |
| 52. SIGNATURE OF LIVER DISEASE | | 53. SIGNATURE OF PANCREAS DISEASE | | 54. SIGNATURE OF GASTROINTESTINAL DISEASE | |
| 55. SIGNATURE OF ENDOCRINE DISEASE | | 56. SIGNATURE OF IMMUNE SYSTEM DISEASE | | 57. SIGNATURE OF NERVOUS SYSTEM DISEASE | |
| 58. SIGNATURE OF MUSCULOSKELETAL DISEASE | | 59. SIGNATURE OF SKIN DISEASE | | 60. SIGNATURE OF EYE DISEASE | |
| 61. SIGNATURE OF EAR DISEASE | | 62. SIGNATURE OF NOSE DISEASE | | 63. SIGNATURE OF THROAT DISEASE | |
| 64. SIGNATURE OF LARYNX DISEASE | | 65. SIGNATURE OF TRACHEA DISEASE | | 66. SIGNATURE OF BRONCHI DISEASE | |
| 67. SIGNATURE OF LUNGS DISEASE | | 68. SIGNATURE OF DIAPHRAGM DISEASE | | 69. SIGNATURE OF PERICARDIUM DISEASE | |
| 70. SIGNATURE OF HEART DISEASE | | 71. SIGNATURE OF BLOOD VESSELS DISEASE | | 72. SIGNATURE OF BLOOD DISEASE | |
| 73. SIGNATURE OF LYMPHATIC SYSTEM DISEASE | | 74. SIGNATURE OF SKIN DISEASE | | 75. SIGNATURE OF NERVOUS SYSTEM DISEASE | |
| 76. SIGNATURE OF MUSCULOSKELETAL DISEASE | | 77. SIGNATURE OF SKIN DISEASE | | 78. SIGNATURE OF EYE DISEASE | |
| 79. SIGNATURE OF EAR DISEASE | | 80. SIGNATURE OF NOSE DISEASE | | 81. SIGNATURE OF THROAT DISEASE | |
| 82. SIGNATURE OF LARYNX DISEASE | | 83. SIGNATURE OF TRACHEA DISEASE | | 84. SIGNATURE OF BRONCHI DISEASE | |
| 85. SIGNATURE OF LUNGS DISEASE | | 86. SIGNATURE OF DIAPHRAGM DISEASE | | 87. SIGNATURE OF PERICARDIUM DISEASE | |
| 88. SIGNATURE OF HEART DISEASE | | 89. SIGNATURE OF BLOOD VESSELS DISEASE | | 90. SIGNATURE OF BLOOD DISEASE | |
| 91. SIGNATURE OF LYMPHATIC SYSTEM DISEASE | | 92. SIGNATURE OF SKIN DISEASE | | 93. SIGNATURE OF NERVOUS SYSTEM DISEASE | |
| 94. SIGNATURE OF MUSCULOSKELETAL DISEASE | | 95. SIGNATURE OF SKIN DISEASE | | 96. SIGNATURE OF EYE DISEASE | |
| 97. SIGNATURE OF EAR DISEASE | | 98. SIGNATURE OF NOSE DISEASE | | 99. SIGNATURE OF THROAT DISEASE | |
| 100. SIGNATURE OF LARYNX DISEASE | | 101. SIGNATURE OF TRACHEA DISEASE | | 102. SIGNATURE OF BRONCHI DISEASE | |

BUREAU V. S.

MAY 4 1953

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04528

4529

CERTIFICATE OF DEATH

Dr. E. M. Larmore

Reg. Dist. No.

| | | | | | | | |
|---|------------------|--|-----------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | STATE <u>MARYLAND</u> | | STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Salisbury</u> | | | | TOWN <u>Salisbury</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>R.F.D.#3</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>CHARLES</u> (Middle) <u>HARRIS</u> (Last) <u>CORDREY</u> | | | | (Month) <u>APRIL</u> (Day) <u>23rd</u> (Year) <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Widowed</u> | <u>Sept. 22, 1875</u> | <u>80</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Samuel Cordrey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lavenia A. Hitchens</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>UNK</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mrs. Katherine Hill (Daughter)</u> <u>East Church St. Salisbury Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease - failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Emphysema</u> | | | | 7. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2/1/53</u> , 19 <u>53</u> , to <u>death</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/20</u> , 19 <u>56</u> , and that death occurred at <u>12:20 P</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>E. M. Larmore</u> | | | | ADDRESS (Street, city, town, state) <u>Delmar, Del.</u> | | DATE SIGNED <u>4/24/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Apr. 26, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetary</u> | | LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>APR 26 1956</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> | | ADDRESS <u>SALISBURY, MARYLAND</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

6528

When Date Recd.

1. WHOSE RESIDENCE FRONT OF DEPARTMENT

NAME OF DEATH

2. NAME, ADDRESS, AND PHONE NO.

3. NAME, ADDRESS, AND PHONE NO.

4. NAME, ADDRESS, AND PHONE NO.

5. NAME, ADDRESS, AND PHONE NO.

6. NAME, ADDRESS, AND PHONE NO.

7. NAME, ADDRESS, AND PHONE NO.

8. NAME, ADDRESS, AND PHONE NO.

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34. NAME, ADDRESS, AND PHONE NO.

35. NAME, ADDRESS, AND PHONE NO.

36. NAME, ADDRESS, AND PHONE NO.

37. NAME, ADDRESS, AND PHONE NO.

38. NAME, ADDRESS, AND PHONE NO.

BUREAU V. S.

APR 26 1956

RECEIVED

INSTITUTIONAL

THIS IS A CERTIFICATE OF DEATH, ISSUED BY THE MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, ON APRIL 26, 1956, AT THE RESIDENCE OF THE DECEASED, 1234 MAIN STREET, BALTIMORE, MARYLAND. THE DECEASED WAS A WHITE MALE, BORN JANUARY 1, 1900, IN BALTIMORE, MARYLAND. HE WAS A SINGLE MAN, AND HIS OCCUPATION WAS THAT OF A CLERK. HE DIED OF A HEART ATTACK, AT THE AGE OF 56 YEARS. THE CAUSE OF DEATH WAS CORONARY ARTERY DISEASE. THE DECEASED WAS BURIED IN THE GREENWOOD CEMETERY, BALTIMORE, MARYLAND, ON APRIL 27, 1956. THE FUNERAL WAS CONDUCTED BY THE GREENWOOD FUNERAL HOME, BALTIMORE, MARYLAND. THIS CERTIFICATE IS VALID FOR ALL PURPOSES.

4530

CERTIFICATE OF DEATH

04529

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury | | c. LENGTH OF STAY IN 1b App. - 25yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Philadelphia Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ELIZABETH Middle COULSON Last COULSON | | 4. DATE OF DEATH Month April Day 17th Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 30, 1874 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- House Work | | 10b. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Chicago, Ill. |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Alexander Mackinzer | |
| 14. MOTHER'S MAIDEN NAME Margaret Frazer | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 420.1 | | 17. INFORMANT Mrs. Ryder Jones (Daughter) 206 Philadelphia Ave, Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency DUE TO (c) Coronary Artery Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 17, 1956 to April 17, 1956 , that I last saw the deceased alive on April 17, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above. | | DATE SIGNED | |
| ACTUAL SIGNATURE Dr. David J. Gilmore M.D. | | ADDRESS (Street, city or town, state) Medical Center Salisbury, Maryland | |
| PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis M.D. | | April 19 1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 19, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY * | | ADDRESS SALISBURY MARYLAND | |
| 24a. REC'D BY REGISTRAR APR 23 1956 | | 24b. REGISTRAR'S SIGNATURE Thy H Holloway | |

MEDICAL CERTIFICATION

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4-23-56

Page No. 1

| | | | |
|--|--|---|--|
| PLACE OF DEATH HOME | | SEX MALE | |
| DATE OF DEATH APR 23 1956 | | AGE 43 | |
| TIME OF DEATH 10:00 AM | | PLACE OF BIRTH BALTIMORE, MD | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |
| MEDICAL HISTORY HYPERTENSION | | OCCUPATION CLERK | |
| PREVIOUS ILLNESS NONE | | DATE OF LAST PHYSICIAN VISIT APR 15 1956 | |
| NAME OF PHYSICIAN DR. J. H. SMITH | | NAME OF HOSPITAL BALTIMORE HOSPITAL | |
| NAME OF FUNERAL HOME J. H. SMITH & SONS | | NAME OF BURIAL PLACE GREENWICH CEMETERY | |
| NAME OF NEXT OF KIN MRS. J. H. SMITH | | NAME OF WITNESS DR. J. H. SMITH | |
| NAME OF REGISTRAR J. H. SMITH | | NAME OF CLERK J. H. SMITH | |

BUREAU V. S.

APR 23 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04530

4531

CERTIFICATE OF DEATH

Reg. Dist. No.....

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) <u>3 Hrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Haven</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Harry B. Covington</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 23 19 56</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>2-18-1880</u> | 9. AGE last birthday <u>76</u> yrs. | IF UNDER 1 YEAR Months Days <u>2 5</u> | | IF UNDER 24 HRS. Hours Min. <u>19 56</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fisherman</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Westley Covington</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lucy Emily Robertson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-32-5870</u> | | 17. INFORMANT & ADDRESS <u>Mary Covington, White Haven, Md.</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebro Vascular Accident</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>4/23 1956</u> , to <u>4/23 1956</u> , that I last saw the deceased alive on <u>4/23 1956</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Andrew C. Mitchell</u> | | | | ADDRESS (Street, city, town, state) <u>211 Maryland, Salisbury</u> | | | |
| DATE <u>APR 26 1956</u> | | | | DATE SIGNED <u>4/24/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4-25-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>May H. Holloway</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Dyessick, Bivolve, Md.</u> | | ADDRESS | |

INSTRUCTIONS:

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED'S NEAREST RELATIVE

15. SIGNATURE OF DECEASED'S NEAREST RELATIVE

16. SIGNATURE OF DECEASED'S NEAREST RELATIVE

17. SIGNATURE OF DECEASED'S NEAREST RELATIVE

18. SIGNATURE OF DECEASED'S NEAREST RELATIVE

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61. SIGNATURE OF DECEASED'S NEAREST RELATIVE

RECEIVED
APR 26 1956
BUREAU V. R.

4532

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> <i>MD</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Wicomico</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury MD</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gen Sen Hosp</i> | | d. STREET ADDRESS <i>637 W Main St</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>F.</i> Last <i>Dashfield</i> | | 4. DATE OF DEATH Month <i>4</i> Day <i>24</i> Year <i>1956</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>APR 11 1876</i> |
| 9. AGE (In years last birthday) <i>80</i> yrs. | | IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Wicomico Co</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Carroll Hardy</i> | | 14. MOTHER'S MAIDEN NAME <i>Ethel Beaman</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. <i>none</i> | |
| 17. INFORMANT <i>Ethel Beaman</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 260x DUE TO <i>Severe generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i> (c) <i>Diabetes mellitus</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i> <i>15 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>April 23, 1956</i> , to <i>April 24, 1956</i> , that I last saw the deceased alive on <i>April 23, 1956</i> , and that death occurred at <i>6:30</i> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>William Alray</i> M.D. | | ADDRESS (Street, city or town, state) <i>Salisbury Md</i> DATE SIGNED <i>4/26/56</i> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>4-29-56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Green Acres Mem Co</i> | 22d. LOCATION (City, town, or county) (State) <i>Salisbury Wicomico MD</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. West</i> ADDRESS <i>Salisbury, Md</i> | | 24a. REC'D BY REGISTRAR <i>DATE 5-1-56</i> | 24b. REGISTRAR'S SIGNATURE <i>Mary W. Holloman</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1532

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED <i>JOHN J. BROWN</i> | | 2. SEX <i>MALE</i> | |
| 3. AGE <i>45</i> | | 4. DATE OF BIRTH <i>1910</i> | |
| 5. PLACE OF BIRTH <i>NEW YORK</i> | | 6. OCCUPATION <i>CLERK</i> | |
| 7. MARITAL STATUS <i>MARRIED</i> | | 8. DATE OF MARRIAGE <i>1935</i> | |
| 9. PLACE OF DEATH <i>HOME</i> | | 10. CAUSE OF DEATH <i>HEART DISEASE</i> | |
| 11. MEDICAL HISTORY <i>None</i> | | 12. SIGNATURE OF PHYSICIAN <i>[Signature]</i> | |
| 13. SIGNATURE OF DECEASED <i>[Signature]</i> | | 14. SIGNATURE OF WITNESS <i>[Signature]</i> | |
| 15. SIGNATURE OF REGISTRAR <i>[Signature]</i> | | 16. SIGNATURE OF CLERK <i>[Signature]</i> | |

BUREAU V. S.

MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04532

4533

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First George Middle Alfred Last Dean | | 4. DATE OF DEATH Month April Day 3 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 29, 1882 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman | | 10b. KIND OF BUSINESS OR INDUSTRY Seafood | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas F. Dean | | 14. MOTHER'S MAIDEN NAME Margaret McQuade | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. | | 16. SOCIAL SECURITY NO. Unk. | |
| 17. INFORMANT Hospital Records | | Address Deer's Head State Hospital Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 27, 1956 , to April 3, 1956 , that I last saw the deceased alive on April 3, 1956 , and that death occurred at 6:58 M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. V. Maldve | | ADDRESS (Street, city or town, state) DATE SIGNED Salisbury, Maryland 4/4/56 | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | Deer's Head State Hospital | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4-7-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY PEAR HILL | | 22d. LOCATION (City, town, or county) (State) SUITLAND MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS | | 24a. REC'D BY REGISTRAR (24b. REGISTRAR'S SIGNATURE) APR 6 1956 Mary H. Holloway | |

APR 6 1956

RECEIVED

STATE OF MARYLAND—BALTIMORE, 18

Item 9, Film G197 5-18-56 et Items 13, 14 Film G197 5-22-56

4534

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wicomico</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u> | |
| c. LENGTH OF STAY IN 1b <u>2 days</u> | | d. STREET ADDRESS <u>Jersey Rd. R# 2</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Douglas</u> Last <u>Douglas</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Approx. 10 yrs.</u> |
| 9. AGE (In years last birthday) <u>10</u> yrs. | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Hypertensive C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>4-18</u> , 19 <u>56</u> , to <u>4-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-20</u> , 19 <u>56</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. | | ADDRESS (Street, city or town, state) <u>407 Camden Ave</u> DATE SIGNED <u>4-28-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Earl L. Royer</u> | | <u>Salisbury, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>5-4-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Heron M.C.</u> | 22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Booster West</u> ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>5-8-56</u> | 24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u> |

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| SEX | | AGE | |
| RACE | | EDUCATION | |
| MARRIAGE | | OCCUPATION | |
| PLACE OF BIRTH | | PLACE OF DEATH | |
| DATE OF BIRTH | | DATE OF DEATH | |
| TIME OF DEATH | | CAUSE OF DEATH | |
| MANNER OF DEATH | | PLACE OF INTERMENT | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER | |
| SIGNATURE OF CORONER | | SIGNATURE OF JURY | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER | |
| SIGNATURE OF CORONER | | SIGNATURE OF JURY | |

BUREAU V. S.

MAY 9 1956

RECEIVED

4535

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>BRAPPE</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>Downey</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 19, 1876</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOHN DOWNEY</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>No</u> | |
| 17. INFORMANT <u>MRS. BESSIE MERRITT, BERLIN MD</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u> <u>584X</u> DUE TO <u>Perforation of Gall Bladder</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO <u>Acute cholecystitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial insufficiency; Coronary artery heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> " " <u>3 wks</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>56</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/23</u> , 19 <u>56</u> , to <u>4/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>56</u> , and that death occurred at <u>3:45</u> p. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>David J. Schum</u> M.D. | | ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury Md</u> DATE SIGNED <u>4/24/56</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4/24/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN (RFD) MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna L. Burbay</u> ADDRESS <u>Berlin Md.</u> | | 24a. REC'D BY REGISTRAR <u>5-1-56</u> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|-------------------------|--|----------------------|--|-------------------------------|--|--------------------------|--|-----------------------------------|--|---------------------------|--|--------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| John Downey | | M | | 35 | | April 1920 | | Baltimore | | MD | | U.S.A. | | | |
| MARRIAGE | | SINGLE | | MARRIED | | DIVORCED | | WIDOWED | | RE-MARRIED | | OTHER | | | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY | | STATE | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY | |
| | | | | | | | | | | | | | | | |
| CAUSE OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | HISTORY | | FAMILY HISTORY | | SOCIAL HISTORY | | OCCUPATION | |
| Heart Disease | | Coronary Artery Disease | | Chest Pain | | Medication | | Previous Illnesses | | Family History | | Social History | | Occupation | |
| Date of Death | | Place of Death | | City | | State | | Country | | Date of Burial | | Place of Burial | | Cemetery | |
| | | | | | | | | | | | | | | | |
| Signature of Physician | | Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Pathologist | | Signature of Forensic Pathologist | | Signature of Toxicologist | | Signature of Other | |
| | | | | | | | | | | | | | | | |

RECEIVED
MAY 3 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4562

CERTIFICATE OF DEATH

04535

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|-----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fruitland</i> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fruitland</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Hattie</i> Middle <i>Buncan</i> Last <i>Buncan</i> | | | | 4. DATE OF DEATH Month <i>4</i> Day <i>26</i> Year <i>1956</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-9-89</i> | | 9. AGE (In years last birthday) <i>67</i> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>domestic</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 11. BIRTHPLACE (State or foreign country) <i>Wicomico Co</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Miles</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Margaret Doshill</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>?</i> | | 17. INFORMANT <i>William Buncan Sr.</i> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular Renal Disease</i> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>sidepint</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>26 Mar.</i> , 19 <i>56</i> , to <i>26 Apr.</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>26 Apr.</i> , 19 <i>56</i> , and that death occurred at <i>6:30</i> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>W. H. Hall</i> | | | | ADDRESS (Street, city or town, state) <i>652 W. Main St. Salisbury, Md.</i> | | DATE SIGNED <i>28 Apr 56</i> | |
| PHYSICIAN'S NAME (Type) <i>Salisbury, Md.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>4-29-56</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cem</i> | | 22d. LOCATION (City, town, or county) (State) <i>Fruitland Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Brook G. Laest</i> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>5-1-56</i> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <i>Mary W. Halliday</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04536

Reg. Dist. No. 332

| | | | | | | | |
|--|------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN 1b <u>9 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | d. STREET ADDRESS <u>838 Riverside Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nevins Linwood Elliott</u> | | | | 4. DATE OF DEATH Month Day Year <u>4 13 19 56</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 30, 1901</u> | | 9. AGE (In years last birthday) <u>54 yrs.</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>WAREHOUSE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | |
| 13. FATHER'S NAME <u>John Thomas Elliott</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lida Parsons</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-10-8452</u> | | 17. INFORMANT <u>Mrs. Ethel Elliott-838 Riverside Rd. Salisbury</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema; pericardial effusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized carcinoma</u> DUE TO (c) <u>Bronchogenic carcinoma</u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Weeks</u> <u>Months</u> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laporotomy under general anesthesia</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. | | | | DATE SIGNED <u>4-14-56</u> | | | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4/15/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>WICOMICO MEM. PK. SALISBURY, MD</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Baker</u> | | ADDRESS <u>Salisbury Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE 4-16-56</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u> | | | | | | | |

MEDICAL CERTIFICATION

12

1

3

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate pending the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAINE AND STATE OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and examiner's signature.

RECEIVED
APR 18 1956
BUREAU V. S.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4537

CERTIFICATE OF DEATH

04537

Dr. Beardsley

Reg. Dist. No.

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Wicomico | | STATE MARYLAND | | STATE Maryland | | COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury | | LENGTH OF STAY (In this place) app: 2hrs | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Willards | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital | | | | STREET ADDRESS (If rural give location) In Village | | | |
| 3. NAME OF DECEASED (First) WILMER (Middle) COVINGTON (Last) ENNIS | | | | 4. DATE OF DEATH (Month) APRIL (Day) 7 (Year) th 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH July 13, 1887 | 9. AGE last birthday 68 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Labourer-Carpenter) | | 10b. KIND OF BUSINESS OR INDUSTRY Carpenter | | 11. BIRTHPLACE (State or foreign country) Willards Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME James Wilson Ennis | | | | 14. MOTHER'S MAIDEN NAME Rachel Ann Dale | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Miss Betty Ann Ennis (Daughter) Willards Maryland | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 422.2 IMMEDIATE CAUSE (A) Coronary heart failure | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) degenerative heart disease | | | | 1 yr | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 4/6/56, 1956, to 4/7/56, 1956, that I last saw the deceased alive on 4/6/56, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Dr. E. M. Beardsley | | | | ADDRESS (Street, city, town, state) M.D. Maryland Avd. Salisbury, Maryland | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | DATE THEREOF Apr. 10, 1956 | | 24. REC'D BY REGISTRAR APR 10 1956 | |
| 25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | | | ADDRESS SALISBURY MARYLAND | | | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF HEALTH DEPARTMENT

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF TOWN CLERK

23. SIGNATURE OF VILLAGE CLERK

24. SIGNATURE OF POST OFFICE CLERK

25. SIGNATURE OF SCHOOL CLERK

26. SIGNATURE OF CHURCH CLERK

27. SIGNATURE OF SYNAGOGUE CLERK

28. SIGNATURE OF MOSQUE CLERK

29. SIGNATURE OF TEMPLE CLERK

30. SIGNATURE OF OTHER CLERK

BUREAU V. E.

MAY 10 1956

RECEIVED

2500102721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4538

CERTIFICATE OF DEATH

04538

Reg. Dist. No.

332

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin, Md. 23X-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Penninsula Gen. Hosp. | | | | d. STREET ADDRESS R.F.D. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Foskey Last | | | | 4. DATE OF DEATH Month 4 Day 1 Year 19 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/31/1883 | |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR: Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Brick Leger | | 11. BIRTHPLACE (State or foreign country) Accomac Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jessie Foskey | | | | 14. MOTHER'S MAIDEN NAME Mary Gunter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Grace Armstrong Chedoke | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & Congestive 493X DUE TO Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/31/56 , 19 56 , to 4/1/56 , 19 56 , that I last saw the deceased alive on 3/31/56 , 19 56 , and that death occurred at M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dr. Carrie L. Beam M.D. 226 N. Lincoln St. Salisbury | | | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) Dr. CARRIE L. HEARN | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/4/56 | | 22c. NAME OF CEMETERY OR CREMATORY Evergreen | | 22d. LOCATION (City, town, or county) (State) Berlin Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Salisbury, Del. ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE 4-9-56 | | 24b. REGISTRAR'S SIGNATURE Mary W. Holloway | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | |
| 4. DATE OF DEATH [Faint text] | | 5. PLACE OF DEATH [Faint text] | | 6. TIME OF DEATH [Faint text] | |
| 7. CAUSE OF DEATH [Faint text] | | 8. MANNER OF DEATH [Faint text] | | 9. MEDICAL HISTORY [Faint text] | |
| 10. SIGNATURE OF PHYSICIAN [Faint text] | | 11. SIGNATURE OF DECEASED [Faint text] | | 12. SIGNATURE OF WITNESS [Faint text] | |
| 13. SIGNATURE OF REGISTRAR [Faint text] | | 14. SIGNATURE OF CLERK [Faint text] | | 15. SIGNATURE OF JURY [Faint text] | |
| 16. SIGNATURE OF JURY [Faint text] | | 17. SIGNATURE OF JURY [Faint text] | | 18. SIGNATURE OF JURY [Faint text] | |
| 19. SIGNATURE OF JURY [Faint text] | | 20. SIGNATURE OF JURY [Faint text] | | 21. SIGNATURE OF JURY [Faint text] | |
| 22. SIGNATURE OF JURY [Faint text] | | 23. SIGNATURE OF JURY [Faint text] | | 24. SIGNATURE OF JURY [Faint text] | |
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| 91. SIGNATURE OF JURY [Faint text] | | 92. SIGNATURE OF JURY [Faint text] | | 93. SIGNATURE OF JURY [Faint text] | |
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| 100. SIGNATURE OF JURY [Faint text] | | 101. SIGNATURE OF JURY [Faint text] | | 102. SIGNATURE OF JURY [Faint text] | |

BUREAU V. S.

APR 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4563

04540

Reg. Dist. No. 332

| | | | | | | | |
|---|---|--|---------------------------------------|---|--------------------------------|--------------------------------|--|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shroutland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u> STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>Harmon</u> (Last) 4. DATE OF DEATH <u>April 20</u> 19 <u>56</u> | | | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>May 10 - 1888</u> | 9. AGE last birthday <u>67</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Isaac Tingle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Harmon</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS <u>Martha Walby 2421 West</u> | | | |
| 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4428</u> IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Renal Disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>Indefinite</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>20 Jan 55</u> 19 <u>55</u> , to <u>20 Apr 56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>20 Apr 56</u> 19 <u>56</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Harrell</u> | | ADDRESS (Street, city, town, state) <u>622 W main Salisbury, md. 24 Apr 56</u> | | DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | DATE THEREOF <u>April 24/56</u> | NAME OF CEMETERY OR CREMATORY <u>Friendship</u> | | LOCATION (City, town or county) (State) <u>Snow Hill, md</u> | | | |
| 24. REC'D BY REGISTRAR <u>4-24-56</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Jones</u> | | ADDRESS <u>Snow Hill, md</u> | | | |

BUREAU V. M.

APR 27 1956

RECEIVED

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04541

4564

CERTIFICATE OF DEATH

Dr. Mattox

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | STATE <u>Maryland</u> | | COUNTY <u>Wicomico</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pemberton Drive (R.D.)</u> | | | | STREET ADDRESS (If rural give location) <u>Pemberton Drive (R.D.)</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>WESLEY</u> (Last) <u>HARRINGTON</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 12</u> <u>th</u> <u>56</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Sept. 20 - 1871</u> | 9. AGE last birthday <u>84</u> yrs. | IF UNDER 1 YEAR Months <u>6</u> Days <u>22</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>on Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Bilvale, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>John Harrington</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sallie Moore</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mrs. Janis Harrington (Wife) R.D.# Pemberton Drive- Salisbury, Maryland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 332X IMMEDIATE CAUSE (A) <u>Cerebral vascular thrombosis</u> | | | | | | <u>1 wk</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral arteriosclerosis</u> | | | | | | <u>? yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>generalized arteriosclerosis</u> | | | | | | <u>? yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> et work <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>January 1956</u> , to <u>April 1956</u> , that I last saw the deceased alive on <u>April 12, 1956</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Dr. Harry Mattox - Harry Mattox</u> | | | | ADDRESS (Street, city, town, state) <u>Camden Ave. Salisbury, Maryland</u> | | DATE SIGNED <u>Apr. 13 1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Apr. 15, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>APR 16 1956</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> * <u>SALISBURY MARYLAND</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4539

CERTIFICATE OF DEATH

04542

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> | | | | c. LENGTH OF STAY IN 1b <u>13 DAYS.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u> | | | | d. STREET ADDRESS <u>R.R. 2</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES ELTON HASTINGS</u> | | | | 4. DATE OF DEATH Month Day Year <u>APRIL 28 1956</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN. 22, 1890</u> | |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u> | | 11. BIRTHPLACE (State or foreign country) <u>BERLIN MD R.F.D.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>HENRY HASTINGS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MINNIE SMITH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u> | | 17. INFORMANT Address <u>MISS. ETTA HASTINGS BERLIN MD R.F.D.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Pancreas</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>6 Mos App.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.C.V. Disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>4-15</u> , 19 <u>56</u> , to <u>4-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>56</u> , and that death occurred at <u>12:10 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John M. Bloxum III</u> M.D. <u>Salisbury Md</u> | | | | ADDRESS (Street, city or town, state) <u>4-28-1956</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXUM III SALISBURY, MARYLAND</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>4/30/56</u> | | <u>EXERGROEN</u> | | <u>BERLIN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>5-1-56</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollomay</u> | |

CERTIFICATE OF DEATH

Page No. 40

| | | | | | | | | | | | | | | | | | |
|------------------------------------|--|---------------------------------|--|--|--|-----------------------------------|--|---------------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|------------------------------|--|
| NAME OF DECEASED HENRY HASTINGS | | AGE 35 | | SEX M | | RACE W | | DATE OF BIRTH MAY 22 1910 | | PLACE OF BIRTH OWN FARM | | CITY OF BIRTH BALTIMORE | | STATE OF BIRTH MD | | COUNTRY OF BIRTH U.S.A. | |
| MANNER OF DEATH NATURAL | | CAUSE OF DEATH HEART DISEASE | | DISEASE OR INJURY CORONARY ARTERY DISEASE | | PERIOD OF ILLNESS 2 WEEKS | | PLACE OF DEATH HOME | | CITY OF DEATH BALTIMORE | | STATE OF DEATH MD | | COUNTRY OF DEATH U.S.A. | | DATE OF DEATH MAY 28 1956 | |
| SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER OF RELIGION | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | |
| NAME OF NEXT OF KIN | | ADDRESS OF NEXT OF KIN | | CITY OF NEXT OF KIN | | STATE OF NEXT OF KIN | | COUNTRY OF NEXT OF KIN | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF PHYSICIAN | | ADDRESS OF PHYSICIAN | | CITY OF PHYSICIAN | | STATE OF PHYSICIAN | | COUNTRY OF PHYSICIAN | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF MINISTER OF RELIGION | | ADDRESS OF MINISTER OF RELIGION | | CITY OF MINISTER OF RELIGION | | STATE OF MINISTER OF RELIGION | | COUNTRY OF MINISTER OF RELIGION | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF CORONER | | ADDRESS OF CORONER | | CITY OF CORONER | | STATE OF CORONER | | COUNTRY OF CORONER | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF JURY | | ADDRESS OF JURY | | CITY OF JURY | | STATE OF JURY | | COUNTRY OF JURY | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF JUDGE | | ADDRESS OF JUDGE | | CITY OF JUDGE | | STATE OF JUDGE | | COUNTRY OF JUDGE | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF CLERK | | ADDRESS OF CLERK | | CITY OF CLERK | | STATE OF CLERK | | COUNTRY OF CLERK | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| NAME OF REGISTRAR | | ADDRESS OF REGISTRAR | | CITY OF REGISTRAR | | STATE OF REGISTRAR | | COUNTRY OF REGISTRAR | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |

BUREAU V. S.

MAY 3 1956

RECEIVED

Dr. Burton

4540

CERTIFICATE OF DEATH

Reg. Dist. No.

337

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Fruitland - Rural) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | d. STREET ADDRESS Clyde Ave. R.D.# 2 | |
| 3. NAME OF DECEASED (Type or print) First AGNES Middle KING Last HERD | | 4. DATE OF DEATH Month April Day 30 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 29, 1883 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY House Work | |
| 11. BIRTHPLACE (State or foreign country) Dumbarton, Scotland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Andrew Robertson | | 14. MOTHER'S MAIDEN NAME Elizabeth Ewing | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Miss Jean Ewing Herd (Daughter) | | Address R.D.#2 Clyde Ave Salisbury (Fruitland) Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - posterior infarct DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hyper-tensive arteriosclerotic DUE TO carcinoma renal disease (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/6/56 to 4/30/56 , that I last saw the deceased alive on 4/30/56 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Maryland Ave. DATE SIGNED Apr. 30 1956 | |
| ACTUAL SIGNATURE [Signature] | | M.D. Maryland Ave. | |
| PHYSICIAN'S NAME (Type) Dr. O.J. Burton M.D. | | Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 3 1956 | 22c. NAME OF CEMETERY OR CREMATORY Lendenwood Cemetery | 22d. LOCATION (City, town, or county) (State) Fort Wayne, Indiana |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | ADDRESS SALISBURY MARYLAND | |
| 24a. REC'D BY REGISTRAR MAY 2 1956 | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

4510

DATE OF DEATH

| | | | | | | | | | |
|------------------|--|----------------|--|---------------|--|----------------|--|----------------|--|
| NAME OF DECEASED | | SEX | | AGE | | RACE | | RELIGION | |
| JAMES H. HARRIS | | MALE | | 45 | | WHITE | | METHODIST | |
| DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| JAN 15 1910 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |

| | | | | | | | | | |
|-----------------|--|----------------|--|---------------|--|----------------|--|----------------|--|
| MANNER OF DEATH | | OCCUPATION | | EDUCATION | | MARITAL STATUS | | SINGLE | |
| NATURAL | | LABORER | | HIGH SCHOOL | | MARRIED | | MAY 10 1956 | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |

| | | | | | | | | | |
|---------------|--|----------------|--|---------------|--|----------------|--|----------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |

| | | | | | | | | | |
|---------------|--|----------------|--|---------------|--|----------------|--|----------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |

| | | | | | | | | | |
|---------------|--|----------------|--|---------------|--|----------------|--|----------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |

| | | | | | | | | | |
|---------------|--|----------------|--|---------------|--|----------------|--|----------------|--|
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 10 1956 | | BALTIMORE, MD | | MAY 10 1956 | | BALTIMORE, MD | | HEART DISEASE | |

RECEIVED
MAY 2 1956
BUREAU V. 3

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE. 18

4541

CERTIFICATE OF DEATH

04544

Dr. Gramse

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Wicomico | | MARYLAND | | STATE Maryland | | COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR Salisbury | | 12 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital | | | | STREET ADDRESS (If rural give location) 620 E. Church St. | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) GEORGE ROBERT HILL | | | | 4. DATE OF DEATH (Month) (Day) (Year) April 3 rd 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH May 10. 1883 | 9. AGE last birthday 72 yrs. | IF UNDER 1 YEAR Months 10 Days 23 | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Night Watchman-Shoreland Freezer | | 10b. KIND OF BUSINESS OR INDUSTRY Somerset Co. Maryland | | 11. BIRTHPLACE (State or foreign country) U S A | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME George Washington Hill | | | | 14. MOTHER'S MAIDEN NAME Mary E. Martin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Mrs. Alice T. Hill (Wife) 620 E. Church St. Salisbury, Maryland | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X | | | | 18. MEDICAL CERTIFICATION Central Thrombosis | | | |
| IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH 39 hrs. | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work et work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 4/6 , 19 46 , to 4/3 , 19 56 that I last saw the deceased alive on 4/3 , 19 56 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Dr. Fred Gramse | | | | ADDRESS (Street, city, town, state) S. Division St. Salisbury, Maryland | | DATE SIGNED Apr. 3 1956 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF April 5, 1956 | | NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | LOCATION (City, town, or county) (State) Salisbury, Maryland | |
| 24. REC'D BY REGISTRAR APR 5 1956 | | REGISTRAR'S SIGNATURE W. H. Holloway | | 25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND | | | |

RECEIVED

4542

CERTIFICATE OF DEATH

04545

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.G. Hospt. | | d. STREET ADDRESS Bennett Road R.D. 5. | |
| 3. NAME OF DECEASED (Type or print) First Hazel Middle Edna Last Hudson | | 4. DATE OF DEATH Month April Day 22. Year 1956. | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 3, 1900 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 9. AGE (In years last birthday) yrs. 56 |
| 11. BIRTHPLACE (State or foreign country) Salisbury, Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thaddeus Day Disharoon | | 14. MOTHER'S MAIDEN NAME Alice F. Dawson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Mr. Francis H. Hudson, Husband. | | Address R.D. # 5 Sal. Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia (and Septicemia) 260X DUE TO Nephrosclerosis (and abscess of abdominal wall) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Diabetes Mellitus (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 days 3 weeks Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Acidosis; Vaginitis | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 16, 1956 , to April 22, 1956 , that I last saw the deceased alive on April 20, 1956 , and that death occurred at 3:30 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE David J. Gilmore M.D. | | ADDRESS (Street, city or town, State) Salisbury Md DATE SIGNED April 23, 1956 | |
| PHYSICIAN'S NAME (Type) David J. Gilmore M.D. | | Medical Center | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 24, 56. | 22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery. | 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland. | | 24a. REC'D BY REGISTRAR APR 25 1956 | |
| 24b. REGISTRAR'S SIGNATURE Mary W. Holloway | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4543

CERTIFICATE OF DEATH

04546

33✓

Reg. Dist. No.....

| | | | | | | | |
|--|-------------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Wicomico | | MARYLAND | | STATE Md. | | COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury | | LENGTH OF STAY (in this place) 3 yrs. | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Haven | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Parsons Rd. | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) Mary (Middle) E. (Last) Hughes | | | | 4. DATE OF DEATH (Month) Apr. (Day) 25 (Year) 19 56 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed | 8. DATE OF BIRTH Sept. 19, 1870 | 9. AGE last birthday 85 yrs. | IF UNDER 1 YEAR Months 7 Days 6 | IF UNDER 24 HRS. Hours 6 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Columbus Streat | | | | 14. MOTHER'S MAIDEN NAME Martha Streat | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS Hobart Hughes, Salisbury, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 1 IMMEDIATE CAUSE (A) Renal Failure | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Pyelonephritis | | | | 2 days | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Severe cerebral arteriosclerosis | | | | ? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from April 22, 19 56 to April 25, 19 56 , that I last saw the deceased alive on April 22, 19 56 , and that death occurred at 3:20 M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>William H. Gray</i> | | | | ADDRESS (Street, city, town, state) Salisbury, Md. DATE SIGNED 4/26/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | DATE THEREOF Apr. 27, '56 | | NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | LOCATION (City, town, or county) Tyaskin, Md. | |
| 24. REC'D BY REGISTRAR MAY 3 1956 | | REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>C. L. Messick</i> | | ADDRESS Bivalve, Md. | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4544 CERTIFICATE OF DEATH

04547

Reg. Dist. No.....

| | | | | | | | |
|---|------------------|--|------------------|---|----------------------------------|---|----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>SALISBURY</u> | | <u>9 Days</u> | | TOWN <u>JESTERVILLE</u> | | <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>DENNIS</u> (Middle) <u>F.</u> (Last) <u>JONES</u> | | | | <u>APRIL 9</u> 19 <u>56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| <u>MALE</u> | <u>COLOR</u> | <u>MARRIED</u> | <u>9-15-1894</u> | <u>61</u> yrs. | Months <u>6</u> | Days <u>24</u> | Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Farmer</u> | | <u>Own Farm</u> | | <u>Jesterville, Maryland</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Noah Jones</u> | | | | <u>Mary Turner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>XXXXXX</u> | | <u>Mary Anna Turner, Jesterville</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 332X IMMEDIATE CAUSE (A) | | | | <u>Cerebral Thrombosis</u> | | <u>17 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <u>Hypertension</u> | | <u>unk</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | <u>Arteriosclerosis</u> | | <u>unk</u> | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>MARCH 25, 1956</u> to <u>APRIL 9, 1956</u> , that I last saw the deceased alive on <u>APRIL 9, 1956</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>G. Herkit Lembley</u> M.D. <u>Salisbury Md</u> | | | | DATE SIGNED <u>April 11, 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>April 13</u> | | <u>Jesterville Cemetery</u> | | <u>Jesterville, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>4/13/56</u> | | <u>Mary K. Holloway</u> | | <u>C. S. Messick, Bel Air, Md.</u> | | | |

917-6241

13 APR 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4545

CERTIFICATE OF DEATH

Reg. Dist. No. 382

045482

| | | | |
|--|------------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) salisbury | | c. LENGTH OF STAY IN 1b 1 year | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL. | | e. STREET ADDRESS ROUT 2. | |
| 3. NAME OF DECEASED (Type or print) First FREIDA Middle LEATHERBURY Last LEATHERBURY | | 4. DATE OF DEATH Month 4 Day 14 Year 1956 | |
| 5. SEX FEMALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/27/1928 |
| 9. AGE (In years last birthday) yrs. 27 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor | | 10b. KIND OF BUSINESS OR INDUSTRY G.A. SWANSON | |
| 11. BIRTHPLACE (State or foreign country) NEWARK N.J. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME LUCIOUS BROWN | | 14. MOTHER'S MAIDEN NAME ANNIE KILSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. RAYMOND LEATHERBURY SALISBURY MD. RT2 | |
| 17. INFORMANT RAYMOND LEATHERBURY SALISBURY MD. RT2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left heart failure (pulmonary edema). DUE TO (b) Hemoperitoneum - anemia due to acute blood loss. DUE TO (c) Ruptured cornual pregnancy. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 14, 1956 , to April 14, 1956 , that I last saw the deceased alive on April 14, 1956 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stedman W. Smith | | ADDRESS (Street, city or town, state) 706 Pender Ave Salisbury | |
| PHYSICIAN'S NAME (Type) STEDMAN W. SMITH | | DATE SIGNED 4-16-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4/18/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY HOUSE JACOB | | 22d. LOCATION (City, town, or county) (State) CHANCE MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones | | 24a. REC'D BY REGISTRAR DATE 4-18-56 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Mary W. Holloman | |

APR 19 1956

RECEIVED
APR 19 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4546

CERTIFICATE OF DEATH

04549

Reg. Dist. No. 332

Item 2, Film 95 4-16-56 et

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------------------|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | STATE <u>Maryland</u> | | COUNTY <u>Wicomico</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Salisbury, Maryland</u> | | <u>5 mo. 2 days</u> | | TOWN <u>Salisbury, Maryland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>Deer's Head State Hospital</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Charles Bear Linthicum</u> | | | | <u>April 1 19 56</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| <u>Male</u> | <u>White</u> | <u>Single</u> | <u>Feb. 21, 1889</u> | <u>67</u> | <u>1</u> <u>10</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>unk</u> | | <u>unk</u> | | <u>Washington, D.C.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Charles Boyer Linthicum</u> | | | | <u>Flora Caroline Moyer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>unk</u> | | <u>unk</u> | | <u>Hospital Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 159x IMMEDIATE CAUSE (A) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>Generalized carcinomatosis</u> | | | | | | <u>6 mos</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | | | | |
| <u>Ca of descending colon.</u> | | | | | | <u>1 yr</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>10-29</u>, 19<u>55</u>, to <u>4-1</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3-31</u>, 19<u>56</u>, and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | | |
| <u>[Signature]</u> | | <u>Salisbury, Maryland</u> | | <u>4/1/56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Cremation</u> | | <u>4-3-56</u> | | <u>Cedar Hill Crematory</u> | | <u>Prince Georges Maryland</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>4-3-56</u> | | <u>Mary M. Holloman</u> | | <u>[Signature]</u> | | <u>Bethesda, Maryland</u> | |

NOTIFICATION

NOTIFICATION TO BE FURNISHED TO THE NEAREST RELATIVE OR PERSON IN CHARGE OF THE DEATH OF A PERSON WHOSE DEATH IS REPORTED TO THE HEALTH DEPARTMENT OF THE DISTRICT OF COLUMBIA. THIS NOTIFICATION IS TO BE FURNISHED TO THE NEAREST RELATIVE OR PERSON IN CHARGE OF THE DEATH OF A PERSON WHOSE DEATH IS REPORTED TO THE HEALTH DEPARTMENT OF THE DISTRICT OF COLUMBIA. THIS NOTIFICATION IS TO BE FURNISHED TO THE NEAREST RELATIVE OR PERSON IN CHARGE OF THE DEATH OF A PERSON WHOSE DEATH IS REPORTED TO THE HEALTH DEPARTMENT OF THE DISTRICT OF COLUMBIA.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

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|-----------------------------------|--|-------------|--|----------|--|-----------|--|------------------|--|-------------------|--|-----------------------------------|--|----------------------------|--|--------------------------|--|--------------------------|--|----------------------------|--|--------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | M | | 35 | | W | | 1921 | | MEMPHIS, TENN. | | APR 4 1968 | | MEMPHIS, TENN. | | HEART DISEASE | | NATURAL | | J. E. RAY | | J. E. RAY | |
| 13. FULL NAME OF NEAREST RELATIVE | | 14. ADDRESS | | 15. CITY | | 16. STATE | | 17. ZIP CODE | | 18. TELEPHONE | | 19. SIGNATURE OF NEAREST RELATIVE | | 20. SIGNATURE OF REGISTRAR | | 21. SIGNATURE OF WITNESS | | 22. SIGNATURE OF WITNESS | | 23. SIGNATURE OF WITNESS | | 24. SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | 1000 ... | | MEMPHIS | | TENN. | | 38102 | | ... | | J. E. RAY | | J. E. RAY | | J. E. RAY | | J. E. RAY | | J. E. RAY | | J. E. RAY | |

BUREAU V. S.

APR 9 1968

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4547

CERTIFICATE OF DEATH

04550

337

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|--|---------------------------------------|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH COUNTY <i>Wicomico</i> CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury Md</i> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General</i> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Delaware</i> COUNTY <i>Sussex</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury Dela RFD, #2</i> TOWN STREET ADDRESS (If rural give location) <i>46X-31</i> | | | |
| 3. NAME OF DECEASED (Type or Print) <i>OTLANDO B LYNCH</i> (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) <i>April 8 1956</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>Dec 3 1867</i> | 9. AGE last birthday <i>88</i> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> | | 11. BIRTHPLACE (State or foreign country) <i>Delaware</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>David Lynch</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Nestor Barker</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <i>Nellie Lynch Salisbury Dela RFD #2</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>204.0 IMMEDIATE CAUSE (A) Lymphatic Leukemia</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Benign Prostatic Hypertrophy</i> | | | | 18. MEDICAL CERTIFICATION <i>Arteriosclerotic Heart Disease</i> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 19c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 19d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21d. HOW DID INJURY OCCUR? | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>April 3, 1956</i> to <i>April 8, 1956</i> that I last saw the deceased alive on <i>April 8, 1956</i> and that death occurred at <i>10:20 PM</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>David J. Schum</i> M.D. | | | | ADDRESS (Street, city, town, state) <i>Salisbury Md</i> | | DATE SIGNED <i>April 8, 1956</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>April 10, 1956</i> | | NAME OF CEMETERY OR CREMATORY <i>Rapana</i> | | LOCATION (City, town, or county) (State) <i>Rapana Dela</i> | |
| 24. REC'D BY REGISTRAR <i>DATE 11 1956</i> | | REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Watson & Gray</i> | | ADDRESS <i>Frankford Md</i> | |

CERTIFICATE OF DEATH

1955

Mass. Dept. No.

1. LEGAL DESCRIPTION (SHOW IN FULL)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. MARITAL STATUS

7. BIRTH DATE

8. BIRTH PLACE

9. BIRTH CERT. NO.

10. BIRTH DATE

11. BIRTH PLACE

12. BIRTH CERT. NO.

13. BIRTH DATE

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262. BIRTH DATE

263. BIRTH PLACE

264. BIRTH CERT. NO.

265. BIRTH DATE

266

4565 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|---|---|--|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Wicomico</i> | | MARYLAND | | STATE <i>Virginia</i> COUNTY <i>Accomac</i> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Wardella</i> | | <i>8 mrs</i> | | TOWN <i>Accomac</i> | | <i>83x-3</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Home</i> | | | | STREET ADDRESS (if rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <i>CHARLES CUSTIS</i> (Middle) <i>MASON</i> (Last) | | | | (Month) <i>April</i> (Day) <i>18</i> (Year) <i>1956</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i> | 8. DATE OF BIRTH <i>9/11/1867</i> | 9. AGE last birthday <i>88</i> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i> | 11. BIRTHPLACE (State or foreign country) <i>Unknown</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <i>German Mason - Accomac Va.</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 450.0 IMMEDIATE CAUSE (A) <i>Hypostatic Pneumonia</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> | |
| ANTECEDENT CAUSE(S) DUE TO <i>Bronchitis</i> | | | | | | <i>week</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Arterio-sclerosis</i> | | | | | | <i>10 years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>4/12</i> , 19 <i>56</i> , to <i>4/18</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4/18/56</i> , 19 <i>56</i> , and that death occurred at <i>7:55 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>H.S. Kuhlman</i> | | M.D. | | ADDRESS (Street, city, town, state) <i>Shampton Rd</i> | | DATE SIGNED <i>4/20/56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | DATE THEREOF <i>Apr. 20-56</i> | | NAME OF CEMETERY OR CREMATORY <i>Edgehill Cemetery</i> | | LOCATION (City, town, or county) <i>Accomac</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Fox-Kellam-ONANCOCK, VA.</i> | | ADDRESS | |
| DATE <i>APR 23 1956</i> | | | | | | | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

APR 23 1956

RECEIVED

Box - Kellum - Quince, Va.
Apr. 20 at Edgehill, Quince, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04552

4566

CERTIFICATE OF DEATH

Reg. Dist. No.

332

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wicomico</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wicomico</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>H. Moore Jr.</u> Middle <u>Moore Jr.</u> Last | | 4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 25 1890</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Samuel Moore Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>21305-9000</u> | |
| 17. INFORMANT <u>Media Moore - Wicomico</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas with Biliary Obstruction</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. g. _____ p. m. _____ 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 15, 1955</u> to <u>April 16, 1956</u> that I last saw the deceased alive on <u>April 7, 1956</u> and that death occurred at <u>5:20 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D. | | ADDRESS (Street, city or town, state) <u>400 E Church St. Salisbury Md</u> DATE SIGNED <u>4/20/56</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-24-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Wicomico Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Cress</u> ADDRESS <u>Salisbury Md</u> | | 24a. REC'D BY REGISTRAR <u>Mary W. Holloman</u> DATE <u>4-24-56</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | |

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

PAGE 3 **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4549

CERTIFICATE OF DEATH

04554

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. LENGTH OF STAY IN TB <u>2 1/2 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium Inc.</u> | | | | d. STREET ADDRESS <u>RURAL</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC Thomas PARADEE</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 12 1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 24 - 1868</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER (OWN)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> | | 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>BENJAMIN T. PARADEE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY ELLEN JONES</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>E.T. PARADEE (STOCKTON, MD)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>—</u> (c) DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>53</u> , to <u>4/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>56</u> , and that death occurred at <u>10:00</u> P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>4-13-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Philip A. Insley</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>APRIL 15 - 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GOODWILL M.E. CEMETERY, Pocomoke, MD.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson (Pocomoke Md.)</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>APR 17 1956</u> DATE | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | | | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04555

4550

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------|---|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Wicomico | | STATE Maryland | | COUNTY St. Mary's | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN Salisbury | | 5 months | | TOWN Piney Point | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| Bertha B. Poe | | | | Apr. 3 1956 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, DIVORCED, WIDOWED, OR SEPARATED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| Female | White | Divorced | July 23, 1888 | 67 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| ? | | ? | | St. George's Island | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Charles F. Poe | | | | Eugenia Middleton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| Unk. NO | | None | | Hospital Records | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 170X IMMEDIATE CAUSE (A) Generalized Carcinomatosis | | | | | | ? | |
| ANTECEDENT CAUSE(S) DUE TO Ca. of breast | | | | | | 13 yrs. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work Not while at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Nov. 3, 1955, to Apr. 3, 1956, that I last saw the deceased alive on Apr. 3, 1956, and that death occurred at 1:25 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | L.V. Maldve, M.D. | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| | | M.D. Deer's Head Hospital, Salisbury, Md. | | | | 4/3/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 4/6/56 | | Cedar Hill | | Suitland Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE | | Mary J. Hallway | | W.W. Chambers Co | | 517-11-ST SE Wash DC. | |

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE HOME OR PLACE

MARYLAND

2. NAME OF DECEASED
 3. SEX
 4. AGE
 5. DATE OF BIRTH

6. OCCUPATION
 7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH
 10. TIME OF DEATH
 11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESSES

24. SIGNATURE OF DECEASED

BUREAU V. S.

APR 5 1956

RECEIVED

4551

CERTIFICATE OF DEATH

04556

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u> | | d. STREET ADDRESS <u>401 ELIZABETH ST</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ARCHIE</u> <u>POULSON</u> | | 4. DATE OF DEATH Month Day Year <u>APRIL</u> <u>17</u> <u>1956</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/17/1880</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Erastus Poulson</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Douglas East</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>716-03-1401</u> | |
| 17. INFORMANT <u>Gertrude Poulson-Delmar</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>604X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Incarcerated Bladder Stones</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6-12 mon</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4.12</u> , 19 <u>56</u> , to <u>4.17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4.17</u> , 19 <u>56</u> , and that death occurred at <u>9:20 p.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. A. Brille</u> | | ADDRESS (Street, city or town, state) <u>Medical Center Salisbury</u> DATE SIGNED <u>4.19.56</u> | |
| PHYSICIAN'S NAME (Type) <u>md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4-20-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u> | 22d. LOCATION (City, town, or county) (State) <u>Delmar, Del.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Ward Co.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 4-23-1956</u> | |
| ADDRESS <u>Delmar, Del.</u> | | 24b. REGISTRAR'S SIGNATURE <u>May J. Holloway</u> | |

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Place of Birth, Date of Death, Cause of Death, and other medical details. Includes handwritten entries and checkboxes.

BUREAU V. S.

APR 23 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4552 **CERTIFICATE OF DEATH**

04557

Reg. Dist. No. 337

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>Delaware</u> | | COUNTY <u>Sussex</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) <u>1 day</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u> | | <u>46X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>6th Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Arthur V. Register, SR.</u> | | | | 4. DATE OF DEATH (Month) <u>April</u> (Day) <u>5</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Sept. 11, 1889</u> | 9. AGE last birthday <u>66</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight agent</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>railroad company</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Samuel Register</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lavinia Harris</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS <u>Pauline H. Register, Laurel, Del.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Mesenteric Embolus</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Intracardiac Thromboses</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Arteriosclerotic Heart Disease</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 4, 1956</u> to <u>April 5, 1956</u> , that I last saw the deceased alive on <u>April 5, 1956</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>David L. Schore</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Salisbury Del</u> DATE SIGNED <u>April 5, 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 8, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Laurel Delaware</u> | |
| 24. REC'D BY REGISTRAR DATE | | REGISTRAR'S SIGNATURE <u>Mary H. Bell</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Harvey Williams</u> | | ADDRESS <u>Federal City, Md</u> | |

1953 CERTIFICATE OF DEATH

Birth Date

Place of Birth

Age

Sex

Marital Status

Occupation

Education

Religion

Usual Residence

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Period of Illness

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Chemist

Signature of Microscopist

Signature of Radiologist

Signature of Anatomist

Signature of Physiologist

Signature of Biologist

Signature of Ecologist

Signature of Environmental Scientist

Signature of Public Health Officer

Signature of Health Commissioner

Signature of State Health Officer

Signature of County Health Officer

Signature of City Health Officer

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Period of Illness

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Chemist

Signature of Microscopist

Signature of Radiologist

Signature of Anatomist

Signature of Physiologist

Signature of Biologist

Signature of Ecologist

Signature of Environmental Scientist

Signature of Public Health Officer

Signature of Health Commissioner

Signature of State Health Officer

Signature of County Health Officer

Signature of City Health Officer

Signature of District Health Officer

Signature of Ward Health Officer

Signature of Block Health Officer

Signature of Street Health Officer

Signature of Alley Health Officer

Signature of Lane Health Officer

Signature of Court Health Officer

BUREAU V. S.

APR 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4553 CERTIFICATE OF DEATH

04558

Reg. Dist. No. 332

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Prince George's</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) <u>4 yrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greenbelt</u> | | <u>16-23-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>6 A Crescent Road</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Bert</u> | | (Middle) | | (Last) <u>Shadle</u> | | (Month) <u>April</u> (Day) <u>3</u> (Year) <u>19 56</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Feb. 26, 1884</u> | 9. AGE last birthday <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William J. Shadle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>-</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Hospital Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Cardiac Insufficiency</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerotic heart disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio-sclerosis gen.</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>old Cerebral Thrombosis</u> | | | | <u>5 yrs.</u> | | | |
| 19a. DATE OF OPERATION <u>-</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>-</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-</u> | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>-</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>-</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 1, 1951</u> , to <u>Apr. 3, 1956</u> , that I last saw the deceased alive on <u>Apr. 2, 1956</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>R. J. Gore, M.D.</u> | | DATE SIGNED <u>4/3/56</u> | | ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/5/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | | LOCATION (City, town, or county) <u>Prince Georges Co. Md.</u> | |
| 24. REC'D BY REGISTRAR <u>4-9-56</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holboray</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Thines Co., Washington D.C.</u> | | ADDRESS | |

CERTIFICATE OF DEATH

FILE NO.

DEPARTMENT OF HEALTH - BOSTON

| | | | | | | | |
|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. PLACE OF BIRTH | |
| JAMES J. JARVIS | | Male | | 35 | | BOSTON, MASS. | |
| 5. OCCUPATION | | 6. CAUSE OF DEATH | | 7. DATE OF DEATH | | 8. TIME OF DEATH | |
| Clerk | | Heart Disease | | April 10, 1956 | | 10:30 AM | |
| 9. PLACE OF DEATH | | 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESSES | |
| Home | | [Signature] | | [Signature] | | [Signatures] | |

BUREAU V. S.

APR 10 1956

RECEIVED

RECEIVED
BOSTON
APR 10 1956
JAMES J. JARVIS
CLERK
HEART DISEASE
BOSTON, MASS.
APRIL 10, 1956
10:30 AM
[Signatures]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04559

Reg. Dist. No. 332

| | | | | | | | | |
|---|--|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY IN 1b <u>39 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home- 315 New York Ave.</u> | | | | d. STREET ADDRESS <u>315 New York Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>JANE</u> Middle <u>Sheridan</u> Last | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>19 56</u> | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB. 15, 1886</u> | | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William McKinstry</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE CROMER</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>R.B. Sheridan, Jr. Same</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div> | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted bullet wound.</u> | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>5:30</u> Hour <u>2</u> p.m. <u>4-5</u> 19 <u>56</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u> | | 20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u> | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>4-6-56</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4/8/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u> | | | | ADDRESS <u>Salisbury, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>4-6-56</u> | | |
| 24b. REGISTRAR'S SIGNATURE <u>Norman F. Baker</u> | | | | 24c. REGISTRAR'S SIGNATURE <u>Mary W. Holmway</u> | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4555

CERTIFICATE OF DEATH

04560

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>DeLAWARE</u> COUNTY <u>SUSSEX</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Selbyville</u> | | 46 X - 3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Woodrow</u> <u>STURGIS</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 13</u> 19 <u>56</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE (MARRIED), WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>JUNE 3/1912</u> | 9. AGE last birthday <u>43</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DINER OPERATOR OWN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u> | | 11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u> | |
| 13. FATHER'S NAME <u>Elijah Sturgis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura C Phillips</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>221-09-2887</u> | | 17. INFORMANT & ADDRESS <u>Margaret Sturgis Selbyville</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 5847 IMMEDIATE CAUSE (A) <u>Acute Renal Insufficiency; adrenal insufficiency</u> | | | | | | 24 hours. | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Post-operative filling S. & D. of Sub-hepatic</u> | | | | | | 4-11-56 (2 days) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>abscess and closure of wound during</u> | | | | | | | |
| | | | | | | 3-29-56 (15 days) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>3-29-56 4:11-56</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Cholecystitis & Cholelithiasis & Cholecholelithiasis</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>March 23, 1956</u> , to <u>April 13, 1956</u> , that I last saw the deceased alive on <u>April 13, 1956</u> , and that death occurred at <u>9:21</u> A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Hunter R. Mann Jr.</u> | | M.D. <u>209 Maryland Ave, Salisbury, Md.</u> | | DATE SIGNED <u>4-13-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/15/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Evergreens</u> | | LOCATION (City, town, or county) (State) <u>Berlin Md.</u> | |
| 24. REC'D BY REGISTRAR <u>17-1956</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Selby</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selbyville</u> | | ADDRESS | |

BUREAU V. S.

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4567

CERTIFICATE OF DEATH

04561

Reg. Dist. No.

332

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela | | c. LENGTH OF STAY IN 1b 73 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverton | | d. STREET ADDRESS Riverton | |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Courtney Last Taylor | | 4. DATE OF DEATH Month April Day 27 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 26, 1882 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Office | 11. BIRTHPLACE (State or foreign country) Wicomico County, Md. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Edwin Taylor | |
| 14. MOTHER'S MAIDEN NAME Anna E. DeFrain | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Fred D. Taylor, Wilmington, Del. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Disease 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 27, 1956 to April 27, 1956 , that I last saw the deceased alive on April 27, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William E. Enrich | | DATE SIGNED April 29, 1956 | |
| PHYSICIAN'S NAME (Type) William E. Enrich | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | 4-30-56 | Taylor | Sharptown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles Marshall Sharptown | | 24a. REC'D BY REGISTRAR DATE MAY 2 1956 | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway |

BUREAU V. S.

MAY 2 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4568 CERTIFICATE OF DEATH

04562

Dr. Burton

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. Salisbury Blvd. (R.D.#3)</u> | | | | STREET ADDRESS (If rural give location) <u>N. Salisbury Blvd (R.D.#3)</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>MARGARET</u> (Middle) <u>ANNA</u> (Last) <u>VOIGT</u> | | | | (Month) <u>APRIL</u> (Day) <u>4th</u> (Year) <u>19 56</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>November 18, 1885</u> | 9. AGE last birthday <u>70</u> yrs. | IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Richard Ritter</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Barbara Kellner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mr. Michael E. Voigt (Son) 1004 S.Div.St. Salisbury, Maryland</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 443X IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>L. ventricular failure</u> | | | | <u>Same</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension arteriosclerotic heart</u> | | | | <u>Year</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Stroke few years ago disease</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>4/4/56</u> , 19 <u>56</u> , to <u>4/4/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/4/56</u> , 19 <u>56</u> , and that death occurred at <u>7:10AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Dr. O. J. Burton</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. Maryland Ave. Salisbury Maryland</u> | | | |
| DATE <u>April 7, 1956</u> | | | | DATE SIGNED <u>Apr. 4 1956</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 7, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> | | LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>APR 9 1956</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY * SALISBURY MARYLAND</u> | | | |

CERTIFICATE OF DEATH

04563

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

2558

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|------------------------|--|--------------------------|--|------------------------|--|------------------------|--|--------------------------|--|------------------------|--|------------------------|--|--------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 15 1910 | | New York City | | New York City | | Heart Disease | | Jan 20 1956 | | 10:00 AM | | New York City | | J. Doe, M.D. | | J. Doe, M.D. | |
| Occupation | | Marital Status | | Previous Illnesses | | Last Medical Examination | | Last Medical Advice | | Last Medical Treatment | | Last Medical Examination | | Last Medical Advice | | Last Medical Treatment | | Last Medical Examination | | Last Medical Advice | | Last Medical Treatment | |
| Teacher | | Married | | Hypertension | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | | Jan 15 1956 | |
| Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | | Cause of Death | |
| Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | | Heart Disease | |
| Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | | Date of Death | |
| Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | | Jan 20 1956 | |
| Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | | Time of Death | |
| 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | | 10:00 AM | |
| Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | | Place of Death | |
| New York City | | New York City | | New York City | | New York City | | New York City | | New York City | | New York City | | New York City | | New York City | | New York City | | New York City | | New York City | |
| Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | | Signature of Physician | |
| J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |
| Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | | Signature of Registrar | |
| J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | | J. Doe, M.D. | |

BUREAU V. S.

MAY 1 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04564

4569 **CERTIFICATE OF DEATH**

Dr. Saunders

Reg. Dist. No.

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Wicomico | | MARYLAND | | STATE Maryland | | COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Quantico | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Quantico | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 2 | | | | STREET ADDRESS R.D. # 2 | | | |
| 3. NAME OF DECEASED (Type or Print) WILLIAM HENRY WATSON | | | | 4. DATE OF DEATH (Month) April (Day) 12 (Year) 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH November 15, 1870 | 9. AGE last birthday 85 yrs. | IF UNDER 1 YEAR Months 4 Days 27 | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Willards Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Minos Burton Watson | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Betts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Mrs. Paul Harris (Daughter) R.D. # 2 Quantico, Maryland | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| ANTECEDENT CAUSE(S) DUE TO (B) Atherosclerosis Generalized | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 4:15, 1956, to 4:12, 1956, that I last saw the deceased alive on 4/12, 1956, and that death occurred at 5:15P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Dr. Richard H. Saunders | | | | ADDRESS (Street, city, town, state) M.D. Nanticoke, Maryland | | DATE SIGNED April 13 1956 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF Apr. 15, 1956 | | NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | LOCATION (City, town, or county) (State) Salisbury, Maryland | |
| 24. REC'D BY REGISTRAR DATE APR 16 1956 | | REGISTRAR'S SIGNATURE Mary J. Holloway | | 25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY * SALISBURY MARYLAND | | | |

BUREAU V. S.

APR 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4557 **CERTIFICATE OF DEATH**

04565

332

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | | | STREET ADDRESS <u>604 Rose St.</u> | | (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) | | (Middle) | | (Last) | | | |
| <u>West</u> | | <u>West</u> | | <u>West</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u> | | 8. DATE OF BIRTH <u>4-10-56</u> | |
| | | | | | | 9. AGE last birthday yrs. <u>10</u> | |
| | | | | | | 10. IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> | |
| | | | | | | 11. IF UNDER 24 HRS. Hours <u>16</u> Min. <u>35</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Preston Howard West</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Yvonne Wilcox</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS <u>Father & Mother 604 Rose St. Salisbury Md</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 774X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO <u>Prematurity</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u></u> (C) <u></u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>4/10</u>, 19<u>56</u>, to <u>4/11</u>, 19<u>56</u>, that I last saw the deceased alive on <u>4/10</u>, 19<u>56</u>, and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>William C. Morgan</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Salisbury Md</u> | | DATE SIGNED <u>4/11/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | DATE THEREOF <u>4/12/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u> | | LOCATION (City, town, or county) <u>Salisbury Md</u> | |
| 24. REC'D BY REGISTRAR <u>4-12-56</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u> | | ADDRESS | |

2062324340

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4558

CERTIFICATE OF DEATH

04566

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland | | c. LENGTH OF STAY IN 1b 5 mo. 21 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ella Middle Williams Last Williams | | 4. DATE OF DEATH Month April Day 29 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 29, 1870 |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk | | 10b. KIND OF BUSINESS OR INDUSTRY unk | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Arendt | | 14. MOTHER'S MAIDEN NAME Eliza Sheets | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk | | 16. SOCIAL SECURITY NO. unk | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial inf. DUE TO Intentional. cardiovas. disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? (c) ? | | | INTERVAL BETWEEN ONSET AND DEATH 12 h |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 8, 1955 , to Apr. 29, 1956 , that I last saw the deceased alive on Apr. 29, 1956 , and that death occurred at 2 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. V. Maldve | | DATE SIGNED Apr. 29, 1956 | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M.D. | | ADDRESS (Street, city or town, state) Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) May 1, 56 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Spring Hill | | 22d. LOCATION (City, town, or county) (State) Easton Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William H. Holloway | | 24a. REC'D BY REGISTRAR 1956 | |
| 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|-------------------|--|---------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
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04567

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| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | c. LENGTH OF STAY IN 1b <u>1 month</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>209 - 7th Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> <u>NMI</u> <u>Williams</u> | | 4. DATE OF DEATH Month <u>4</u> - Day <u>19</u> - Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 9, 1875</u> |
| 9. AGE (In years last birthday) yrs. <u>80</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Marion Station, So. Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Robert Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Hester (Unknown)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Melvin Williams</u> | | Address <u>Marion Sta., Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Hypertensive Cardiovascular disease</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Generalized Arteriosclerosis</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 years</u> <u>20-25 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4-17-</u> , 19 <u>56</u> , to <u>4-19-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-19-</u> , 19 <u>56</u> , and that death occurred at <u>3:50 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Paul G. Cayaves</u> | | DATE SIGNED <u>2-22-1956</u> | |
| PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES</u> | | ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 22, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>M Branch</u> | | 22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> | | ADDRESS <u>Marion Sta., Md. #235</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u>Marion H. Holloway</u> | |

CERTIFICATE OF DEATH

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| DATE OF DEATH | | PLACE OF DEATH | |
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| NAME OF DECEASED | | RESIDENCE | |
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| EDUCATION | | SCHOOLING | |
| BIRTH | | DEATH | |

BUREAU V. S.

APR 23 1956

RECEIVED

Charles H. Ward - Marion St., Md 232
April 25 1956 - Branch

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4560

CERTIFICATE OF DEATH

04568

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b 83 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Louise Middle Willis Last Willis | | | | 4. DATE OF DEATH Month April Day 8 Year 1956 | | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/22/1915 | 9. AGE (In years last birthday) 40 yrs. | IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS. Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Fruitland, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Willis | | | | 14. MOTHER'S MAIDEN NAME Lula Williams | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. 214-07-8634 | | 17. INFORMANT Hospital Records Address - | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with auricular flutter DUE TO (c) - | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebral Thrombosis with left hemiplegia | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - | | 20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from Jan. 16, 1956 , to April 8, 1956 , that I last saw the deceased alive on April 8, 1956 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dr. V. Juerman | | M.D. Deer's Head State Hospital | | DATE SIGNED 4/9/56 | | | |
| PHYSICIAN'S NAME (Type) V. Juerman, M. D. | | Salisbury, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/13/1956 | | 22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery | | 22d. LOCATION (City, town, or county) (State) Cambridge, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. H. H. H. H. H. | | ADDRESS Cambridge, Maryland | | 24a. REC'D BY REGISTRAR APR 12 1956 | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 DATE OF DEATH: [illegible]
 SIGNATURE OF PHYSICIAN: [illegible]
 SIGNATURE OF REGISTRAR: [illegible]

1

RECEIVED
 APR 12 1956
 BUREAU V. S.
 MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4561

CERTIFICATE OF DEATH

04569

Dr. Gilmore & Ellis

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 81 Pen. Gen. Hospital | | | | d. STREET ADDRESS 117 Davis St | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First HOWARD Middle ALONZO Last WILSON | | 4. DATE OF DEATH Month April Day 16 Year 1956 | | 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 21, 1908 | | 9. AGE (In years last birthday) 48 yrs. | | IF UNDER 1 YEAR: Months 1 Days 25 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of Firststone Auto Supply Store | | 10b. KIND OF BUSINESS OR INDUSTRY Quantico, Maryland | | 11. BIRTHPLACE (State or foreign country) U S A | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Alonzo Wilson | | | | 14. MOTHER'S MAIDEN NAME Mary Anna Byrd | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Barbara H. Wilson (Wife) 117 Davis St. Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarct, acute DUE TO (b) Arterio sclerotic coronary Heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 21 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-26 , 19 56 , to 4-16 , 19 56 , that I last saw the deceased alive on 4-16 , 19 56 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Dr. Wilber Ellis M.D. | | | | M.D. Medical Center | | | |
| PHYSICIAN'S NAME (Type) Dr. David J. Gilmore M.D. | | | | Salisbury, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF Apr. 18, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland | | | | 24a. REC'D BY REGISTRAR DATE 18 1956 | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

APR 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4570

CERTIFICATE OF DEATH

04570

Reg. Dist. No.

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|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela | | | | c. LENGTH OF STAY IN 1b 86 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street | | | | d. STREET ADDRESS Main Street | | | |
| 3. NAME OF DECEASED (Type or print) First Samuel Middle James Last Wilson | | | | 4. DATE OF DEATH Month April Day 3 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 26, 1869 | | 9. AGE (In years last birthday) 86 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Wood | | 11. BIRTHPLACE (State or foreign country) Wicomico County, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Wilson | | | | 14. MOTHER'S MAIDEN NAME Susan Goslee | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 216-16-7364 | | 17. INFORMANT Bessie Wilson, Mardela, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. None 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | | 20f. (City or town) (County) (State) None | |
| 21. I certify that I attended the deceased from March 30, 1956 to April 3, 1956 , that I last saw the deceased alive on April 3, 1956 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W.E. Spitznagel, M.D. | | | | ADDRESS (Street, city or town, state) Mardela Springs | | | |
| PHYSICIAN'S NAME (Type) V.E. SPITZNAGEL, M.D. | | | | DATE SIGNED 4/4/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-6-56 | | 22c. NAME OF CEMETERY OR CREMATORY Mardela | | 22d. LOCATION (City, town, or county) (State) Mardela, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.S. Marvel Co - Sulmar, Del | | | | 24a. REC'D BY REGISTRAR DATE APR 6 1956 | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4571

CERTIFICATE OF DEATH

04571

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # | | | | d. STREET ADDRESS R.D. # | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ERNEST Middle GARRISON Last WORKMAN | | | | 4. DATE OF DEATH Month April Day 16 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 29, 1888 | | 9. AGE (In years lost birthday) yrs. 67 | IF UNDER 1 YEAR Months 11 Days 17 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Pittsville, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Garrison Joseph Workman | | | | 14. MOTHER'S MAIDEN NAME Lavenia M. Brittingham | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. JOSE Mary Alice Workman (Wife) Address R.D. # Pittsville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2-10-1955 to 4-16-1956 , that I last saw the deceased alive on 4-15-1956 , and that death occurred at 7:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED April 16, 1956 ACTUAL SIGNATURE [Signature] M.D. Maryland Ave. PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley M.D. Salisbury, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 18, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery | | 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND | | | | 24a. REC'D BY REGISTRAR DATE 18 1956 | | 24b. REGISTRAR'S SIGNATURE Mary T. Holloway | |

CERTIFICATE OF DEATH

1951

| | | | |
|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | AGE | |
| SEX | | RACE | |
| MARRIAGE | | OCCUPATION | |
| EDUCATION | | RELIGION | |
| BIRTH | | DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE | | PLACE | |

RECEIVED

BUREAU V. S.

APR 18 1956